Respite Pre-Admission Form

All fields are required unless marked "optional"

GENERAL CONSENT

This request is being submitted with the knowledge and consent of names parents/legal guardians. Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at: https://erinoakkids.ca/about-us/about-erinoakkids/accountability/policies/privacy-and-confidentiality

Consent Received: ☐ Yes ☐ No If No, ErinoakKids will not process this referral.

Please set aside at least 30 minutes to complete valuable information about your family member so ErinoakKids' Respite staff can ensure the happiness, safety, and well-being of your family member attending Respite

ERINOAKKIDS' RESPITE SERVICES STREAMS

Please access the ErinoakKids website for descriptions and eligibility criteria for each respite service stream https://www.erinoakkids.ca/all-services/family-supports/respite-services

CLIENT INFORMATION

Date of Birth (dd-mmm-yyyy) _____

Gender ☐Male ☐Female ☐Other

Child's Name
Last Name _____
First Name _____ Middle Name (optional) _____
Health Card # (optional) _____ Version Code _____

Address
Unit#_____ Street# _____ Street Name _____
City _____ Postal Code _____

Parent / Legal Guardian Names

1. Person to Notify *(primary contact - will be the only person notified for services)*

Last name _____ First Name _____
Relationship _____
Phone #1 _____ Phone Type Choose from below:
Phone #2 _____ Phone Type Choose from below:
Email _____
Address ☐Same as client ☐Different from Client *If different from client, please fill out below*
Unit#_____ Street#_____ Street name _____
City _____ Postal Code _____

2. Next of Kin *(secondary contact - optional)*

Last name _____ First Name _____
Relationship _____
Phone #1 _____ Phone Type Choose from below:
Phone #2 _____ Phone Type Choose from below:
Email _____
Address ☐ Same as client ☐ Different from Client *If different from client, please fill out below*
Unit#_____ Street#_____ Street name _____
City _____ Postal Code _____

Has your family member attended ErinoakKids' Respite Program in the last 2 years? ☐Yes ☐No

Please refer to below to advise if family member has had any changes to the following since their last visit:

a. Development, emotional social, psychological needs? ☐Yes ☐No
   If yes, please describe _____
b. Medical Needs ☐ Yes ☐No
   If yes, please describe _____
c. Daily Care Requirements ☐Yes ☐ No
   If yes, please describe _____
d. Behavioural Needs ☐ Yes ☐ No
   If yes, please describe _____

ALL ABOUT YOUR FAMILY MEMBER

What would you like us to know about the important people in your family member's life?

_____

_____

What are your family member's play skills, preferred toys or leisure skills?

_____

_____

What are your family member's strengths and abilities?

_____

_____

What are things your family member dislikes?

_____

_____

How does your family member communicate? (please select all that apply)

☐Words ☐Gestures ☐Sounds ☐Sign Language ☐Alternative Augmentative Communication
☐Pictures/Symbols ☐Other (describe) _____

What culture does your family member identify with?_____

What spirituality does your family member identify with? (e.g. Catholic, Protestant, Christian, Muslim, etc) (optional to answer) _____

Does your family member identify as First Nations, Inuk or Metis? ☐Yes ☐No

MEDICAL NEEDS

Physician: _____ Phone Number: _____

Does your family member have an antibiotic resistant organism such as MRSA, VRE, or c-difficile?
☐ Yes ☐ No

Does your family member have an updated Tetanus vaccination?
☐ Yes ☐ No

Does your family member have allergies?
☐ Yes ☐ No

Allergens: _____
Describe reaction: _____
Prescribed treatment: _____

Current Weight: _____
Current Height: _____

Please describe your family member's underlying medical diagnosis/diagnoses (if known):

_____

_____

Please describe any recent illnesses, hospitalization and surgeries

_____

_____

Summary of Your family member's Medical Fragility and Technological Requirement(s) *(if applicable)*
Please select all that apply

☐Seizure Disorder
☐Daily ☐2 to 4 per/day ☐5 to 10 per/day ☐10+ per/day ☐Other _____

☐Hypertonia

☐Moderate to Severe dystonia

☐Hypotonia

☐Immunocompromised

Please elaborate on any of the above selected boxes within the summary section:

_____

_____

_____

Respiratory Support

☐Chest Physio *describe frequency:* _____

☐Pulse Oximetry *describe frequency (continuous or sporadically):* _____

☐Suctioning

☐Daily ☐2 to 3 hours ☐4 to 8 hours ☐Hourly+

☐Oxygen administration

☐How often used?_____

☐How many litres per hour/oxygen percentage is required?_____

☐CPAP

☐How often used?_____

☐BiPap

☐How often used?_____

☐Cough Assist

☐How often used?_____

☐Tracheostomy/Artificial airway

☐Please describe _____

☐Ventilator

☐How often used?_____

☐G-Tube, GJ-Tube or J-Tube

Type of feeding tube_____

Date of last feeding tube replacement _____

Instructions if feeding tube comes out _____

Type of formula_____

Frequency of feeds_____

Flushes - frequency and amount _____

Positioning during feeds _____

Enteral Feeds: ☐Overnight feeds ☐Special Formulation ☐Continuous Feeds

Additional Information:_____

_____

☐Colostomy/Caecostomy/Malone *please describe* _____

_____

☐Urostomy/Veslcostomy/Mitrofanoff *please describe* _____

_____

☐Vision and Hearing

- Does your family member use glasses or hearing aids?_____
- Does your family member have a vision impairment?_____
- How do you support their safety at home? _____

_____

☐Other Medical Fragility *please describe:* _____

_____

SOCIAL AND EMOTIONAL NEEDS

Are there any development, emotional social, psychological needs that would be important for the Respite staff to know about your family member? (e.g., anxiety, suicidal ideation, depression)

_____

_____

_____

DAILY CARE REQUIREMENTS

Medication Administration of scheduled medications and vitamins/supplements

1. Drug Name: _____ Dose: _____ Frequency: _____
2. Drug Name: _____ Dose: _____ Frequency: _____
3. Drug Name: _____ Dose: _____ Frequency: _____
4. Drug Name: _____ Dose: _____ Frequency: _____
5. Drug Name: _____ Dose: _____ Frequency: _____
6. Drug Name: _____ Dose: _____ Frequency: _____
7. Drug Name: _____ Dose: _____ Frequency: _____
8. Drug Name: _____ Dose: _____ Frequency: _____

Medication Administration for as needed medication (e.g., Tylenol)

1. Drug Name: _____ Dose: _____ Frequency: _____
2. Drug Name: _____ Dose: _____ Frequency: _____
3. Drug Name: _____ Dose: _____ Frequency: _____
4. Drug Name: _____ Dose: _____ Frequency: _____
5. Drug Name: _____ Dose: _____ Frequency: _____

Pharmacy Name: _____ Phone number: _____

Consent to contact Pharmacy: ☐ Yes ☐ No

Please select all that apply

☐ Pain and symptom management

- What do you do to relieve your family member's pain? _____

_____

☐ Skin Care Routine

- Wound care required _____
- How often _____

☐ Additional Monitoring

- Blood glucose monitoring _____
- How often _____
- Appropriate range of blood glucose level _____

☐ Does your family member have a shunt in their brain? ☐ Yes ☐ No

Other Daily Requirement(s): _____

_____

Does your family member require assistance in the following areas?
Please describe all that apply

☐ Toileting

- Describe the routine of taking your family member to toilet _____
  _____
- Does your family member wear diapers or incontinent briefs? _____
- Frequency of changes at home _____
- Do you change your family member's diapers in the night? ☐ Yes ☐ No
- Does your family member require catheters for bladder and bowel emptying? ☐ Yes ☐ No
- Does your family member have a history of constipation? How do you manage this?
  _____
- Does your family member require any equipment for toileting? _____
  _____

☐ Bathing *(if your family member is staying overnight)*

- Describe the level of assistance your family member needs _____
- Frequency _____
- Prefer bath or shower _____
- Does your family member require any equipment for bathing/showering?
  _____

☐ Dressing

- Describe the level of assistance your family member needs _____
  _____

☐ Mealtimes

- Is your family member at risk for coughing and choking on liquids or foods? ☐ Yes ☐ No
- Does your family memeber require assistance with eating/drinking? Please describe
  _____
- What type of cup or bottle is used for drinking? ☐ sippy cup with valve ☐ bottle
  ☐ regular cup ☐ cup with straw
- Does your family member tolerate all food textures? _____
- Does your family member use special utensils? _____
- How does your family member tell you they are hungry? _____
  _____
- Does your family member follow a special diet (e.g. vegetarian, halal, etc)? _____
  _____
- Favourite foods _____
- Disliked foods _____

☐ Bedtime *(If your family member is staying overnight)*

- Which bed does your family member use: ☐ safety-enclosed bed (twin bed with 1-3 ft rails)
  ☐ standard bed (twin bed with 6 inch rails)
- What time do they wake up? _____
- Do they require waking? _____
- What time is bedtime? _____
- What comforts are required, night light, music, blanket or stuffed animal? _____

  _____
- Does your family member nap? If yes, what time and for how long? _____

  _____
- What sleeping/resting position does your family member prefer? _____

  _____

☐ Mobility

- Does your family member require help to transfer from bed to chair? ☐ Yes ☐ No
- Do you use any equipment for transfers? _____

  _____
- Does your family member use equipment to mobilize such as walker or wheelchair?

  _____
- Wheelchair how long can your family member sit in their wheelchair?

  _____
- How can we assist your family member with mobility? _____

  _____
- Is your family member at risk for tripping and falling? ☐ Yes ☐ No
- Please describe how your family member is secured in their wheelchair (e.g. harness, straps, etc)_____

  _____

☐ Swimming

- Is your family member able to go swimming? ☐ Yes ☐ No
- What supports are required? (e.g., life jacket, water walker)_____

  _____
- Does your family member require a swim diaper? ☐ Yes ☐ No

A Personal Assistance Service Device (PASD) is specialized equipment to assist with hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation or positioning or any other routine activity of living. PASDs may include orthotics, wheelchairs, helmets, standers and walkers.

Upon admission, a consent form will be completed to identify a plan to use PASD and to ensure PASD is in good working order.

Does family member wear a helmet? ☐ Yes ☐ No

- Describe use of helmet:_____

Does family member wear braces? ☐ Yes ☐ No

- Does your family member wears braces/orthotics on their arms, legs or back? Please describe

  _____
- When are the braces/orthotics worn? _____
- How long should they be worn? _____

BEHAVIOURAL NEEDS

Would your family member benefit from a Safety Plan during their visit? Please describe/share

_____

_____

Does your family member demonstrate any of the following?
Please select all that apply

Does your family member demonstrate aggression towards others?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does your family member demonstrate aggression towards themselves?

- ☐ Requires medical treatment
- ☐ Requires first aid-treatment
- ☐ Does not require treatment
- ☐ None of the above

Does your family member try to leave the house on their own?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does your family member engage in property destruction?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does problem behaviour occur when you break routine or interrupt activities? If so, describe

☐ Yes ☐ No _____

_____

Does problem behaviour occur when it appears that your family member will not get their way?

☐ Yes ☐ No If yes, describe the things that the your family member often attempts to control

_____

_____

Does problem behaviour occur when you ask your family member to do something they do not want to do? ☐ Yes ☐ No If yes, please describe _____

_____

Does problem behaviour occur when your family member wants your attention? ☐ Yes ☐ No
If yes, please describe _____

_____

How do you know problem behaviour is going to happen? List the behaviours your family member engages in before the onset of problem behaviour_____

_____

How do you calm your family member down once they engage in the problem behaviour?

_____

What actions do you do to distract your family member from engaging in the problem behaviour?

_____

OTHER INFORMATION

Is there any other information that is relevant for the Respite Staff to know about your family member?

_____

_____

_____

_____

Name of person completing the application:
Last Name: _____ First name:_____
Relationship:_____
Date of Completion (dd-mmm-yyyy): _____

Thank you. Please submit the completed form.